

**BRIEF EMPOWERMENT THERAPY;
THE COMPARATIVE EFFICACY AND INTEGRATION OF PRESCRIPTIVE AND
EXPLORATORY BRIEF THERAPY**

by

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ABSTRACT

A review of research literature for the treatment of depression, when compared to systematic observations of differently trained staff, revealed a controversy in the proper implementation of Brief Therapy. The primary focus of such controversy concerned the efficacy of prescriptive (directive, strategic, and cognitive-behavioral) versus exploratory (non-directive, insight-oriented, psycho-dynamic) interventions. Related to this controversy were philosophical differences between various milieus (manipulated therapeutic environments), which appeared to influence the efficacy of either set of interventions.

Observing differences in mood, following prescriptive, exploratory, and combined techniques, within various milieus, a sensitive instrument was selected to measure the comparative efficacy of various matched techniques and milieus. The purpose of the study was to test the hypothesis that no differential outcome measures would result in the comparison of prescriptive and exploratory techniques, with significantly increased efficacy in their integration. Milieus, in which treatments were executed, were further expected to increase the efficacy of those techniques with which they were congruent. In agreement with the expectations, outcome measures revealed significantly higher mood elevations following combined techniques, with unexpected significant interactions between treatments and opposing milieus. The implications of the results contrast with earlier assumptions that prescriptive and exploratory treatments are incompatible, as well as with assumptions of increased efficacy with treatment-milieu congruency.

CHAPTER 1

THE PROBLEM

Introduction

Brief Therapy, designed for increasing the efficiency of psychotherapeutic interventions, has become a popular approach to the impatient treatment of depression, "elevating patient moods by twelve to forty percent" (Blatt and Maroudas, 1992, p. 158). Prior studies of Brief Therapy may, however, be quite misleading. Old controversies between prescriptive (directive, strategic, cognitive-behavioral) and exploratory (non-directive, insight-focused, psychodynamic) therapy have yielded erroneous interpretations of Brief Therapy, polarizing and fragmenting an approach which was originally meant to be eclectic (Clayton and Barret, 1983). Such a growing polarization has confounded research, along with a continuation of "methodological problems, such as erroneous and non-specific treatment conditions, variant therapeutic settings, and nonspecific, differentially gathered outcome measures" (Luborsky, et al, 1971, p. 148).

The following study addresses the aforementioned concerns, exploring more thorough and accurate operational treatment definitions, selecting controlled environments to support treatment conditions, and systematically observing standardized treatment conditions, executions, and data collection. The study tested the hypothesis that no significant differential outcome measures will result in the comparison of prescriptive and exploratory interventions, with significantly increased efficacy in their integration, as well as with intervention- environment congruency.

Development of the Problem

Over the past few decades, the practice of Brief Therapy has been growing in popularity. The efficiency and outcome focused society of the United States, influenced by increasingly

restrictive mental health funding sources, has contributed to "a demand for more 'time-sensitive', 'time-effective,' and 'cost-effective'" (Budman and Gurman, 6) interventions. While Brief Therapy has become increasingly necessary and popular, however, many practitioners of Brief Therapy have been criticized for focusing on efficiency at the expense of empathy, respect, and empowerment.

Among popular criticisms of Brief Therapy has been the presumed tendency of prescriptive (directive, strategic, cognitive-behavioral) therapists to ignore the role of past life experiences, of feelings, and, of the need for personal insights regarding one's ego development (Amendt, et al., 1992). Their chief critics, the exploratory (non-directive, insight-focused, psychodynamic) therapists, have been equally criticized in return, presumably attending to these areas to the extent of losing focus upon immediate concerns, turning rather toward debilitating diagnoses, overly complex treatments, and subsequently enmeshed therapeutic relationships (Anderson, et al., 1992). The debate between these schools of thought reflects a long standing divergence in psychotherapeutic communities (Clayton, et al., 1983), based upon two major schools of thought on the ways in which people change and grow (Cronbach, 1975). According to trend studies by Carlo C. DiClemente and James O. Prochaska (1982), the controversy between prescriptive and exploratory brief interventions has yielded a threatening polarization in the practice of brief therapy, producing novice therapists whom cling rigidly to opposite paradigms (276). Therapists of almost all orientations have moved toward more brief forms of treatment, with competition for third party and government funded payments fueling a struggle to influence the brief therapy movement toward acceptance of their respective views. Consequently, even many experienced brief therapists have become rigidly tied to politically charged theoretical foundations. Considering these factors, a brief therapist might provide a strict psychoanalysis of one's attachment issues and ego development, strict cognitive therapy of one's faulty thinking, strict behavioral modification to

change one's habits, strict family systems therapy to change the way in which a family communicates and functions, or some other inflexible and thereby erroneous manifestation of brief therapy. In their article, "Transtheoretical Therapy: Toward a More Integrative Model of Change," DiClemente and Prochaska propose that such rigidity in practice, encouraged by increasing socio-political debates and economic competition, could "become like a cancer of uncontrolled growth that threatens to destroy the very body of knowledge in which it is growing" (276). This article, supported by the integrative research of Norcross and Goldfried (1992), suggests that such polarizing dynamics within the field create a political climate which breeds "narrowly pragmatic ideologies" (277), reducing therapeutic focus upon the client as a person, and thereby threatening brief therapy's integrity (278).

The Need for the Study

In response to the threat of "losing its integrity to the chaos in divergence" (DiClemente and Prochaska, 276), integrative researchers have recently identified two trends. First, they have described a divergence between prescriptive or exploratory therapies (Lazarus and Beutler, 1993). Paradoxically, they also described examples of increasing prescriptive and exploratory therapy integration (Norcross and Goldfried, 1992). Research on brief therapy for the treatment of depression has further revealed that, while "no consistent difference between the outcome measures of prescriptive and exploratory interventions appeared, either treatment approach paled in comparison to emerging brief eclectic models" (Clayton, 1983, p. 128).

Despite notions that prescriptive and exploratory approaches are incompatible, given their opposing theoretical foundations, integrative therapists have found that treatment efficacy may be increased by the flexibility of technical eclecticism, borrowing techniques from various orientations, including those derived from opposing theories (Beutler, 1983). Studies of increased efficacy with a congruency between milieus and treatments (Luborsky et al., 1971), as well as

between treatments and patient personalities (Pilkonis, 1995), have further appeared to support this technical eclecticism. These studies, which appear as evidence in support of technical eclecticism, are however confounded by insufficient standardization of data collection, uncontrolled therapeutic milieus, and poorly defined operational definitions of treatment, preventing a necessary a "replication and refinement" of outcome measures (Shapiro and Shapiro, 1982).

The Purpose of Further Study

As in any profession, the field of psychotherapy is competitive, demanding accountability, measures of value, and ongoing efforts to market a product or service. Insurance companies, foundations, government entities, and others whom are responsible for the payment of psychological services are increasingly requiring more measurable outcomes, more efficient delivery of services, and a logical rationale for each treatment provided. While there has always been a competitive climate in the field of psychotherapy, recent pressures to provide such efficient, measurable, and logical results have manifested a variety of novel therapeutic orientations, all claiming to be "brief," for the purpose of selling their approaches.

With most of the research on psychotherapy based upon brief durations of treatment, defining Brief Therapy as merely a "time-sensitive, time-effective, and cost-effective" (Budman and Gurman, 1988, p. 6) requires a review of all comparative literature. Because this task would be beyond the scope of this research, the focus of comparison has been narrowed according to diverging prescriptive and exploratory trends in brief therapy. While these two schools of thought have been well defined in descriptive literature, experimental literature has significantly varied in operational definitions and research methods. The following study proposes the necessity of utilizing descriptive literature in improving experimental research, yielding more conclusive evidence of similar outcomes between prescriptive and exploratory styles, with increased efficacy in their integration, as within congruent milieus.

CHAPTER 2

LITERATURE REVIEW

Introduction

The history and evolution of Brief Therapy forms the basis for the following study, as depicted in the following historical literature review. As this review demonstrates, the field of Psychotherapy evolved as established psychoanalytic, strategic, and cognitive behavioral theories were continuously challenged by opposing, often necessarily polarized views, finally moving carefully toward more defined eclecticism (Nichols and Schwartz, 1991, p. 70). This evolutionary process yielded increasingly specific outcome measures, operational definitions, and most effective techniques for the research and treatment of brief therapy.

The Psychoanalytic Roots of Brief Therapy

The first established form of psychotherapy to influence trends toward contemporary Brief Therapy was pioneered by Sigmund Freud, the father of Psychoanalysis. Although psychoanalysis has been seen as a long term treatment, Freud actually utilized brief psychoanalytic therapy in several of his early cases. He was known, in 1906, to have terminated analysis of patients within "six weeks to a year," sometimes completing treatment within "a matter of hours" (Marmor, 1979, p. 150). Freud was also known to experiment with "setting a termination date in advance" (Marmor, 1979, p. 150); a common practice in Brief Therapy today. It was only as Freud's theories grew more ambitiously complex that psychoanalysis became a long term form of treatment, raising debates which split its followers into factions for either short or long term approaches.

The basic notion of original psychoanalytic therapy held that the individual's unconscious

problems were "spawned by the family" (Nichols and Schwartz, 1992, p. 70) during early childhood psychosexual development. Freud believed that, if a patient perceived similarities between the therapist and whomever with which their conflicts arose, such "transference," could be encouraged and analyzed, leading to insight-directed resolution. Psychoanalytic treatment therefore dictated that the therapist take a non-directive role with individual patients, seeking information about their personalities by uncovering developmentally harmful aspects of past relationships.

Freud's non-directive, investigative approach to therapy eventually necessitated long term treatment, inviting criticism. In 1918, psychoanalytic pioneer, Sandor Ferenczi, argued that Freud's long term treatments "neglected the task for the sake of psychological interest, turning analysis into a proving ground for analytic theory" (Ferenczi and Rank, 1925, p.59). Ferenczi thus proposed a return to short term psychoanalysis through what he called "active treatment." Together with Otto Rank, Ferenczi developed this catharsis technique into what Alexander French later termed "corrective emotional experiences," whereby the patients would "work through" childhood emotional experiences by facilitated transference with the therapist. Based on resulting theories of hidden conflicts and internalized anger or depression, related to issues of attachment, separation, and individuation, short term psychodynamic techniques such as therapeutic alliance, catharsis, reality testing, and role modeling were developed into current practices.

Strategic Family Systems Therapy's Influence upon Brief Therapy

While short-term psychodynamic therapy was in its process of development, biological studies of social interaction and general systems began to influence the field toward family systems theories of how families operate, develop, function, interact, and change. This general systems theory, that "the whole is greater than the sum of parts," was applied to families by Gregory Bateson during in the late 1940s and early 1950s. An anthropologist at heart, Bateson examined

the family as an ecological system, with each member representing a functional part of the larger system. Applying Norbert Weiner's mathematical principle of cybernetics, Bateson viewed the family as a self-maintained, mechanistic system, whose dysfunctions were the result of faulty feedback loops, analogous to faulty feedback loops or cycles in machinery. According to Bateson and other cyberneticians, these cycles were driven more by power communication than by internal conflicts, which challenged psychoanalytic definitions of psychological problems, making therapy a process of behavior change, versus a process of growth from insight.

In assuming that family interactions evolve around power and control (Haley, 1976), and are maintained by automatic feedback loops (Bateson), strategic family therapists described families as powerful, rigid systems, requiring clever intervention, thereby discounting the psychoanalytic theory that insight alone produces behavioral change. This negative view of patients was made more positive by Milton Erickson's challenge that individuals and families want to and can rapidly change, given direction toward new and more effective action (Haley, 1976). Prescriptive therapy therefore began as a blend cybernetic and Ericksonian thought.

The Cognitive Behavioral Roots of Brief Therapy

In 1959 Don Jackson, of the aforementioned Bateson Project, founded the Mental Research Institute (MRI) in Palo Alto, California. There, he furthered research in communication and cybernetic theories. It was his small group of strategic family systems therapists, joined by humanistic psychologist, Virginia Satir and others, whom, in the late fifties, conducted research toward the development of contemporary prescriptive brief therapy.

The MRI model included the feedback loop theory of problem maintenance. This theory held that problems are maintained by systemic power struggles, inhibitions prohibiting access to one's intuition, and subsequently repetitive or habitual constructions of ineffective, yet logical solutions. Within the fifties and sixties anti-psychiatric rhetoric and deinstitutionalism, this MRI model was also

shaped by the growing popularity of Cognitive-Behavioral theories.

Cognitive Therapy offered a more collaborative, less diagnostic approach, and, it was easily assimilated into strategic thought. It was not a far stretch for Strategic Brief Therapists to have perceived the mind as having its own feedback loops, which maintained problems through self-defeating and self-limiting, rigid thought structures, and which thereby reinforced themselves through perceptual perseverance. Cognitive theory further offered strategic therapists support of their concept that individuals repeat more of the same solutions, despite past failures, seemingly unable to change solutions without strategic or Ericksonian intervention. Based upon these notions, the role of the prescriptive brief therapist was reinforced as a directive role.

While the MRI model popularized brief strategic approaches to therapy, Aaron Beck's brief treatments of depression, and the Rational Emotive Behavior Therapy (REBT) model of Albert Ellis, also became increasingly popular. Departing from Psychoanalysis, Beck noted that depression seemed to constitute more than internalized anger, as Freud had proposed. In the course of his psychoanalytic practice, Beck had become interested in the "automatic thoughts" of his patients, which he theorized as clues to reinforcing structures of underlying depressive, self-defeating or self-defeating thought and belief systems. Beck's studies on Brief therapy for the treatment of depression therefore began to focus largely upon how patients automatically perceived and structured their experiences, assuming that "automatic thoughts" revealed more permanent thought structures. His goal was to help patients to identify and eliminate depressive thoughts and beliefs, which he believed were the cause of chronic depression.

Influenced by Systemic the Cybernetic research, Beck viewed cognitive structures, or sets of related perceptions and beliefs, as self maintained, thereby allowing individuals to feel secure in their illusion of predictable reality. Like strategic therapists, Beck's view of automatic thoughts and feedback loops warranted that the therapist be directive in prescribing a cognitive and/or

behavioral course of action. The Rational Emotive Behavior Therapy (REBT) model of Albert Ellis further added emotions as a part of the feedback loop, in relation to how emotions are perceived, created by perceptions, and reinforced by or causal in relation to behaviors. The cybernetic similarities between strategic therapy, REBT, and Beck Cognitive-Behavior Therapy allowed for the eclecticism of Prescriptive Brief Therapy.

Contemporary Trends and the Treatment of Depression

Although prescriptive brief therapists were eclectic in their approach, the socio-political and economic climate of health care reform, as well as the long standing debates between insight focused psychoanalysis and action-focused cognitive and behavioral approaches, continued to prevent the integration of prescriptive and exploratory approaches. Within this climate, the recidivism rate of affective disorders, such as depression, were on the rise (Blatt and Maroudas, 1992). While the majority of outcome studies revealed that this recidivism rate correlated with shorter durations of treatment, placing brief therapy in question, other studies of brief therapy demonstrated that long term treatments were no more effective (Blatt and Maroudas, 1992). As discussions of brief therapy for the treatment of depression ensued, brief therapists of all orientations argued that recidivism rates, and the increase in depressed patients in general, were due to increased public awareness of and interest in seeking help for depression. Brief therapists further joined forces in arguing that recidivism was a part of developmental and therapeutic processes, not attributable to treatment length. It was in the defense of brief therapy for the treatment of depression, that the wall between prescriptive and exploratory therapists fell, allowing for collaborative research which yielded evidence that consumers were more likely to respond to treatments which fit within their phenomenological or cognitive framework, gaining progress in noncontinuous treatment stages, with periods of remission as a part of the therapeutic process (Clayton and Barret, 1983).

While the defense of brief therapy brought prescriptive and exploratory brief therapists together in many ways, creating the common factors of empathy, consumer-orientation, and validation, public awareness of theoretical debates once again paradoxically fueled the competition between them. Studies at this time demonstrated that increased consumer awareness influenced consumers' choices of therapist, also influencing the effectiveness of interventions (Cade and O'Hanlon, 1993). Some therapists responded to these studies by providing a myriad of requested interventions, becoming eclectic (Duncan, 1992). Other therapists responded to these studies with blind allegiance to a paradigm (Lazarus and Beutler, 1993), resisting eclecticism. Eventually, trends of divergence and non-specific eclecticism appeared in the works of novice therapists, whom essentially redefined brief therapy through inconsistently eclectic, or even erroneous implementations (Clayton and Barret, 1983).

As the erroneous practices of novice integrative practitioners became apparent, novice eclecticism was discouraged (Lazarus and Beutler, 1993). Meanwhile, myths about prescriptive and exploratory brief therapy, perpetuated by controversy, continued to misguide novice therapists toward increasingly rigid and polarized practices. As a result, prescriptive therapy soon developed the reputation of being unfeeling and overly instrumental (Amendt et al, 1992). Another result of controversy was the false notion that exploratory therapy entailed merely opening up a Pandora's box of past, unresolvable issues, without offering direction toward behavior change (Frank, 1983). In many ways, these myths were later self-fulfilled.

As myths about prescriptive and exploratory therapy spread, debates surrounding the recidivism of depression caused wider divergence. This increasingly competitive environment of health care reform and consumer awareness influenced practitioners to protect their respective approaches. Characteristic of their long standing contest, the two schools began to theorize ways in which the rate of recidivism might also be attributable to their competitors' techniques.

Prescriptive brief therapists attributed the increasing recidivism of depression upon the dependent relationships fostered by exploratory approaches (O'Hanlon, 1991), offering their efficient, problem-focused treatments of depression as a response to the limitations of psychoanalysis. They further challenged the exploratory theories of internalized anger from reactivated or triggered attachment issues as the core of depression, stating that depression was no more than a habit, perpetuated by faulty cognition and dysfunctional or maladaptive social interactions. The prescriptive approach to depression included paradoxical interventions, framing, disputing negative thoughts about oneself, one's experiences, and one's future, cognitive, behavioral, and linguistic homework assignments, and other various covert and overt directives, designed to break patterns of thinking, systemic interactions, and behavior. Each of these treatments was demonstrated as effective by specific studies of their individual efficacy (Clayton and Barret, 1983; Blatt and Maroudas, 1992; Budman et al, 1988). Outcome measures for the prescriptive treatment of depression were primarily action oriented, yet also demonstrated that each intervention had the effect of elevating patient moods (Maroudas, 1992, p. 158).

In an unscientific manner similar to prescriptive brief therapists, exploratory therapists attributed the rise of recidivism in depressed patients to what they labeled as an unfeeling, overly instrumental, prescriptive approach (Amendt et al, 1977). Exploratory therapists claimed that prescriptive therapists contributed to a "revolving door of treatment" by failing to acknowledge and work through pertinent unconscious material (Cade and O'Hanlon, 1993). They further challenged prescriptive theories of depression as habitually perpetuated faulty cognition and dysfunctional social interactions, as a theory which presents the danger of discounting deep attachment issue, internalized oppression, anger, and blame. The exploratory approach to depression, included transference analysis, fostering insight by linking cognition to past events, catharsis, role modeling, behavioral rehearsals, psychodrama, working through, and reality testing.

While prescriptive brief therapists struggled against the established insight and relationship oriented approaches, exploratory brief therapists faced long standing myths which threatened their ability to claim efficiency in treatment. Having had psychoanalytic backgrounds, many exploratory therapists were presumed to be long term therapists, based upon notions that traditional psychoanalysis was fundamentally long term. In response to criticisms from exploratory therapists, prescriptive therapists had also stereotyped all exploratory therapists as extremists for long term, complex analysis. This claim served to draw funds away from them, especially with the difficulty in measuring and proving outcomes from insight-focused techniques.

As debates between prescriptive and exploratory approaches to depression became more public and politically charged, funding for comparative and integrative research became more available. The chronicity of depression was a problem which researchers had yet to solve. The resulting examinations of prescriptive and exploratory therapy brought clarity to the long standing debates, demonstrating the myths of their divergence.

During a period of emerging eclecticism, transtheoretical research revealed that therapy need not be either insight or action oriented, demonstrating that those in long term remission had achieved both treatment objectives, by following insight with action (Clayton and Barret, 1983). Other integrative studies demonstrated that depressive cognition need not be either symptoms of underlying anger or habitual causes of sadness, but could plausibly be both (Dobson, 1986). While these integrative studies proved that prescriptive and exploratory therapy were compatible, debates continued as to whether or not such integration diluted original theoretical foundations, threatening each model's integrity. These debates manifested the integrative method, technical eclecticism.

The solution to opposing, presumably incompatible theories, proposed by technical eclectics, was to disregard theory, creating a new theory for the approach to depression, deduced from the identification and testing of proven techniques from a variety of orientations. As they

examined techniques from various perspectives, they found that many of the criticisms against prescriptive and exploratory therapy were based upon erroneous assumptions (Clayton and Barret, 1983). The result of their studies was a new form of integrative therapy, designed to meet the various combined treatment goals.

The first erroneous assumption addressed by technical eclectics was the assumption that prescriptive brief therapists were unfeeling and overly instrumental. This erroneous assumption had been based upon early prescriptive writings which neglected to address issues in remaining problem focused and directive, while continuing to address emotional and ethical concerns (Frank, 1983). The effect of these erroneous perceptions was a self-fulfilling prophecy. Novice or improperly trained practitioners tended to practice prescriptive brief therapy in a distant, coercive, and overly directive manner (Anderson et al., 1992). In review of several articles which later addressed "the myth of the unfeeling strategic therapist" (Amendt, et al., 1992), and the ethics of properly utilized directives (Anderson et al., 1992; Duncan, 1992; and Held, 1992), technical eclectics redefined techniques taken from the prescriptive model, improving their efficacy (Lazarus and Beutler, 1993).

The second erroneous assumption addressed by technical eclectics was the assumption that exploratory brief therapists fostered dependency in the therapeutic relationship, prolonging therapy by becoming overly analytical, involved, and deterministic. These myths also created a self-fulfilling prophecy, in that novice exploratory practitioners became enmeshed, overestimating the impact of past events (Blatt and Maroudas, 1992). Upon examining the true intent and execution of exploratory therapy, technical eclectics found that properly facilitated transference relationships actually increased autonomy and elevated moods, addressing past, unresolved attachment and individuation issues, and allowing for the past to become a resource rather than an developmental obstacle (Blatt and Maroudas, 1992).

The discovery of erroneous assumptions regarding prescriptive and exploratory therapy allowed technical eclectics to merge the two models with relative ease. By removing the false dichotomy that had been created by controversy, the goals for prescriptive and exploratory therapy could be seen as more compatible. Even the historically opposing theories began to reflect similarities with regard to increasing cognitive awareness. The result was a movement toward increased open-mindedness regarding integration, and a refinement of techniques used to foster both the insight sought by exploratory therapists, and the action sought by prescriptive brief therapists. This open-mindedness further allowed for the convergence of prescriptive and exploratory theories of depression as both a manifestation of past conflicts, and a result of habitually negative thought processes.

After years of debate and divergence between prescriptive and exploratory models, technical and transtheoretical eclecticism was not enough to convince many practitioners to surrender their allegiance to single theories. Studies of comparative efficacy and integrative models were carefully scrutinized by such practitioners, revealing varied operational definitions and integrative practices. Many comparative and integrated studies were further criticized as utilizing outcome measures which failed to be congruent with the goals of each model, or were considered invalid due to confounds such as variant milieus and patient characteristics. Unfortunately, these criticisms appear to have been well founded. While technical and transtheoretical models appeared promising, they lacked the standardized criteria necessary for testing validity through replicated studies.

Summary:

Reviewing the history and evolution of Brief Therapy, the process of natural psychotherapy integration yields a mold for present and future models. With a knowledge of how political and economic forces have created false dichotomies, contemporary therapists may

evaluate the degree to which their perspectives have been biased, preventing once criticized dogmatic practices. Even novice practitioners may now utilize systems of integration by understanding how the seeds of current eclecticism were planted.

From an analysis of the current trends, it appears that Psychoanalysis is still woven into most perspectives, in that many practitioners acknowledge the richness of one's family of origin. In most practices today, the intake and assessment process entails a detailed social history, implying the value of past information on development, hidden conflicts, and internalized anger (depression). Psychoanalysis can also be seen in the free flowing process still utilized by eclectics, implying the value of insight through free associations and a genuine stream of consciousness.

In addition to the influences of Psychoanalysis, the seeds planted by Strategic Family Therapists are revealed in current eclectic practices through descriptions of the powerful and complex influences of family and social systems upon individual behavior. Such descriptions merge with the psychoanalytic concepts of past family and social influences, broadening the wisdom of psychoanalysis to acknowledge the individual's current social situations. The contribution of Strategic Family Therapy has been illuminated most profoundly within the notions that families and communities bear some responsibility in fostering or allowing for positive change to occur.

Nurturing the growth of seeds planted by Psychoanalysis and Strategic Family Systems therapy, Cognitive Behavioral theories depict the individual mind as the processor of influences, stored as resulting beliefs and belief systems which drive all emotion and behavior. In the current eclectic model, Cognitive Therapy is the primary focus, integrating other therapy models, while also integrating the fragments of individual lives.

CHAPTER 3

METHODOLOGY

Introduction

The following study aims to address the issues of polarization and inconclusive research in the practice of Brief Therapy, exploring more thorough and accurate operational treatment definitions, selecting controlled environments to support treatment conditions, and systematically observing standardized treatment conditions, executions, and data collection. The purpose of the study is twofold. First, the study aims to define more specific criteria for eclectic brief therapy, thus allowing for the increased validity of replicated studies. Second, the study aims to demonstrate the comparative efficacy of differential brief interventions and their integration. The hypothesis is that no significant differential outcome measures will result in the comparison of prescriptive and exploratory interventions, with significantly increased efficacy in their integration, as well as with intervention-environment congruency.

Sample and Population

Participants for this study were selected according to inclusion criteria in prior studies on the brief treatment of depression, as well as criteria used to determine patient selection for brief intervention. These criteria included 1) informed consent, 2) ego strength, 3) the capacity for trust, 4) the capacity for emotional and cognitive expression, 5) a diagnosis of major, minor, or intermittent depressive disorder, 6) a score of ten or more on the Beck Depression Inventory, and no current evidence of psychosis, alcoholism, immediate suicidal risk, or bipolar disorder. Eligible participants were randomly assigned to one of three treatment conditions. Participants' mean age was 28 years ($SD=5$). Their average amount of education was 12 ($SD=2$). The ranges

and diversity of races, ages, and education levels were consistent with census data for depressed populations, gathered through analysis of various agency and government records. Due to limited resources, the majority of participants were recently victimized female residents of a crisis house or shelter, and few men were available as participants. Consequently, only 46 men were represented in the sample of 186. Sampling locations within impoverished areas and within government funded programs also precluded middle and upper classes. This was demonstrated by an average annual household income of \$15,000 to \$25,000 ($SD=4.5$), and a maximum household income of \$35,000. Other demographics and information gathered for analysis included geographic location, rural versus urban residency, employment, past hospitalizations, recently (within past two weeks) prescribed psycho tropic medications, life span psycho social histories, and current social supports, anticipating these factors as limitations.

Research Design

The first objective of the study was to form an eclectic brief therapy model that might lend itself to consistent outcome measures. Using technical eclecticism, techniques from each opposing theory were evaluated according to comparative and integrative literature, distinguishing the most effective treatments for clinical depression. These treatments were then examined and compared, in terms of their theoretical origin. Finally, theoretical perspectives were de-constructed, in order to develop an holistic theory which would be inclusive of all selected techniques.

Treatment Conditions

1. Prescriptive Brief Therapy:

The first treatment condition included paradoxical interventions, framing, disputing negative thoughts about oneself, one's experiences, and one's future, cognitive, behavioral, and linguistic homework assignments, imagery, and role playing. Each of these action-oriented, strategic, cognitive behavioral, and directive approaches were selected based upon demonstrated

effectiveness in repeated prior clinical trials (Budman and Gurman, 1988). The techniques were executed by the researcher and trained assistants only, utilizing operational definitions as provided by the following referenced guides:

Paradoxical Interventions:

Based upon Cade and O'Hanlon's, A Brief Guide to Brief Therapy (1993), participant's were instructed to engage in isolatory behaviors and depressive cognition, which they claimed to be involuntary, in order to demonstrate to them that they could control the thoughts and behaviors which reinforced their depressive moods.

Framing:

Based upon Cade and O'Hanlon's, A Brief Guide to Brief Therapy (1993), participants were provided with new, more positive interpretations, conclusions, and/or attributions regarding their particular depressive situations (re-framing), later challenged to develop their own re-frames without assistance (de-framing).

Pattern Changing:

Based upon Brief Therapy: The Rational Emotive Method (1992), by Albert Ellis, participants were educated regarding all or none thinking, perfectionism, and control issues which reinforce depression, then challenged to dispute their own negative thoughts regarding themselves, their experiences, and their future, given cognitive, behavioral, and linguistic homework assignments.

Rational-Emotive Imagery:

Based upon Brief Therapy: The Rational Emotive Method (1992), by Albert Ellis, participants were taught to use imagery in practicing new behaviors, reactions, and thoughts in preparation for depressive interpersonal situations.

Role Playing:

Based upon Brief Therapy: The Rational Emotive Method (1992), by Albert Ellis, participants were taught to use role playing and rehearsal exercises, later assigned to take the social risk of exposing behaviors, reactions, and thoughts imagined to result in rejection.

2. Exploratory Brief Therapy:

The second treatment condition included the techniques of catharsis, therapeutic alliance, cognitive learning, operant conditioning, transference analysis, role modeling, and reality testing. Each of these insight-oriented, non-directive approaches were also selected based upon demonstrated effectiveness in repeated prior clinical trials (Marmor, 1979). These techniques, like those of the first condition, were executed by the researcher and trained assistants only, utilizing operational definitions as provided by the following referenced guides:

Catharsis:

Based upon Davanloo's Basic Principles and Techniques in Short-Term Dynamic Psychotherapy (1978), participants were re-exposed to past depressive situations, working through residual hidden conflicts and internalized anger, facilitating transference through the exploration and re-enactment of past interpersonal interactions, and then facilitating the expression of emotions toward a person from the past, whom the participant had projected onto the therapist.

Therapeutic Alliance:

Based upon John Bowlby's Attachment and Loss (1973), a positive transference relationship was formed, building rapport through active listening, validation, demonstrated concern, demonstrated interest, and unconditional positive regard for the participant.

Cognitive Learning:

Based upon Menninger's Theory of Psychoanalytic Technique (1973), participants were offered interpretations of present emotional experiences and concerns as linked to past conflicts.

Operant Conditioning:

Based upon Davanloo's Basic Principles and Techniques in Short-Term Dynamic Psychotherapy (1978), participants were provided with indications of approval or disapproval, fostering insight into transference related maladaptive behaviors. During this catharsis, however, participants were provided more positive or constructed responses to emotional transference expressions of anger, with the goal of encouraging expression, versus erroneously repressing internalized anger.

Transference Analysis:

Based upon John Bowlby's Attachment and Loss (1973), participants were offered interpretations of free associations, dreams, resistances, and interactions with the therapist, as related to past losses, separation-individuation issues, and other attachment issues which were hypothesized as having retarded emotional growth and subsequent coping skills.

Role Modeling:

Based upon Bowlby's Attachment and Loss (1973), participants were encouraged to identify the therapist as a pseudo-parent role and model of new behaviors.

Reality Testing:

Based upon Menninger's Theory of Psychoanalytic Technique (1973), participants were encouraged to examine their perceptions in relation to the past and present.

3. Brief Empowerment Therapy:

The third treatment condition, based upon technical eclecticism, transtheoretical eclecticism, and the "empowerment" philosophies of solution-focused therapy, was labeled "Brief Empowerment Therapy". This condition was labeled "Empowerment Therapy" due to its emphasis on educating participants as experts on their own depression, offering them a variety of perspectives to consider, while directing them toward a focus upon new possibilities, more positive interpretations of their own behavior and situation, and collaboratively brainstorming new or historically successful solutions.

Due to earlier findings that the goals of both prescriptive and exploratory therapy could be combined, the goal of the Brief empowerment Model was to begin by fostering a positive therapeutic relationship, and an atmosphere of trust and respect, creating an empowering, equalized therapeutic relationship. The basis of this primary goal was to diffuse what prescriptive therapists have defined as power struggles, encouraging a collaborative, therapeutic relationship, while encouraging active participation and pattern changing. This technique was further intended to fulfill the goals of Exploratory Therapy by enhancing therapeutic alliance, motivating participants to gain insight, and fostering development through an exploration of formative childhood relationships and other historical factors linked to present concerns. The techniques combined for the third treatment condition were arranged according to the treatment goals of both models, in order to increase the congruency between treatment goals and measures, while establishing a replicable eclectic design, thereby answering to prior criticisms of technical and transtheoretical eclecticism. Another criticism of integrative models has been the assumption that past technically and transtheoretical eclectic models tended to dilute the theories upon which integrated techniques had been based. This anticipated criticism was addressed through comprehensive operational definitions, accounting for the theoretical foundations of both Prescriptive and Exploratory therapy. After lengthy discussion with practitioner-research assistants, each session was specifically operationalized by the following definitions:

SESSION I: Therapeutic Alliance, Re-framing Role Modeling and Operant Conditioning:

Based upon operational definitions described in treatment conditions one and two, a transference relationship was built, establishing trust and rapport through active listening, validation, and demonstrated interest, positive regard, and concern for the participant. During this stage, participants were provided with positive or hopeful interpretations or attributions regarding their particular depressive situations, also conditioned by indications of approval or disapproval, in order to later provide them with insight into transference related maladaptive behaviors.

The combined goals of session one were to build a safe, educational environment, conducive to a productive and collaborative therapeutic relationship, skill development (reframing), and the exploration

of more positive choices in thinking and behavior. These outcome goals were consistent with both prescriptive and exploratory therapy, in that both approaches emphasize the importance of "common factors," empathy, validation, and rapport in establishing a relational groundwork for future interventions. Differences between the theoretical foundations of prescriptive and exploratory interventions were discussed among researchers, prior to session one.

One of the issues in combining the techniques used in session one pertained to a focus upon past versus present thoughts and behaviors. In order to preserve the integrity of both prescriptive and exploratory models, while integrating their respective techniques, the prescriptive goal of refraining and role modeling, in order to eliminate habitual negative thoughts, was argued as compatible with the exploratory goal of eliminating erroneous thoughts that are linked to past conflicts. This argument was based upon the fact that habits stem from the past, and that "habitual negative thoughts" and "hidden conflicts" might be seen as one in the same. Therefore, both prescriptive and exploratory therapy were rationalized as emphasizing a change in one's cognitive patterns through the revelation of habitual or unconscious thoughts and behaviors.

SESSION II: Paradoxical Interventions, De-framing and Cognitive Learning:

Based upon operational definitions described in treatment conditions one and two, participant's were instructed to engage in isolatory behaviors and depressive cognitions, demonstrating how their choice of thoughts and behaviors might reinforce depression. While engaging in this assignment, staff were asked to monitor the visible impact, providing support to prevent major depressive episodes. Once the assignments were completed for one hour, participants were debriefed, then offered various interpretations of present emotional experiences and concerns as either possibly linked to past conflicts and anger, to transference, or to learned habits of negative or self-defeatist thinking. Finally, participants were instructed to define more positive or hopeful interpretations or attributions regarding their particular depressive situations.

The combined goals of session two were to uncover resistance to treatment, encourage insight into the participant's control over their depression, increase the participant's insight into links between

their depression and past conflicts, anger, and relationships, and engage participants in the process of refraining to more positive interpretations and attributions regarding their situations. These outcome goals were consistent with both prescriptive and exploratory therapy, in that both prescriptive and exploratory therapy include insight as a process in therapy. Although prescriptive literature has stated that insight is not necessary toward reaching outcome goals, criticizing insight as the goal of exploratory therapy, prescriptive therapists do define different kinds of insight as the goal of paradoxical and framing techniques. In exposing feedback cycles, for example, the prescriptive therapist aims to provoke insight. This dispels the myth that prescriptive and exploratory are necessarily dichotomous. Rather than representing an insight versus action dichotomy, they actually may be seen as representing an integration of insight plus action.

SESSION III: Pattern Changing, Reality Testing, and Rational-Emotive Imagery:

Based upon the operational definitions described in treatment condition one, participants were educated regarding the all or none thinking, perfectionism, and control issues which reinforce depression, challenged to dispute their own negative thoughts regarding themselves, their experiences, and their future, when involved in conflicts or other depressive situations. Participants were also taught to use imagery in practicing alternative behaviors, reactions, and thoughts which might replace those aforementioned, given cognitive, rational-emotive, behavioral, and linguistic homework assignments such as free writing journal analysis, list making, humor in imagery, and self talk.

SESSION IV: Transference Analysis, Role Playing, and Catharsis:

Based upon operational definitions described in treatment conditions one and two, participants were taught to use role playing and rehearsal exercises in practicing new behaviors, reactions, and thoughts, in preparation for depressive interpersonal situations. During role playing exercises, participants were re-exposed to past depressive situations, working through residual hidden conflicts and internalized anger. This "reality testing" process involved creating a safe environment conducive to transference and free expression, facilitating the expression of emotions toward a person from the past, whom the participant had projected onto the therapist, while providing more positive or constructive responses to

emotional transference expressions of anger. Finally, participants were offered interpretations of free associations, dreams, resistances, and interactions with the therapist. These exploratory interpretations offered theories of present depression as linked to past losses, separation-individuation issues, and other attachment issues which were hypothesized as a disruption in emotional growth. Further prescriptive interpretations were provided with respect to taking social risks, learning new coping skills, and trying out new behaviors, reactions, and thoughts in situations erroneously imagined to result in rejection. Session four aligned with both prescriptive and exploratory models, both increasing each participant's awareness of the relationship between their past and present thoughts and behaviors, and thereafter providing them with opportunities to practice alternative thoughts and behaviors. While the exploratory aspects of session four were incongruent with prescriptive theories and goals, this insight + action model, versus the classic insight or action dichotomy, served to technically integrate treatment goals.

Treatment Settings

Treatment settings for the present study were selected based upon their congruence with treatment conditions one and two, analyzed in terms of therapeutic foci and underlying theoretical foundations. Treatment settings were also selected based upon the willingness of those within the setting to participate in controlling the therapeutic milieu. Another criteria for selecting the treatment settings involved seeking experienced brief therapists and researchers, within the settings, to act as consultants and ensure ethics within the milieu.

While both settings were transitional programs for the "severely mentally ill," requiring that depressed patients be stabilized with antidepressant medication, the only available settings had some limitations. First, control of the therapeutic milieu, within clinical environments, was limited by the need to honor facility policies and procedures, as well as to ensure that each participant receive appropriate services. Second, as stated earlier, the majority of participants were recently victimized female residents of either a crisis house, or of a shelter/mental health facility, with both settings primarily catering to women. Third, both settings catered primarily to low income, unemployed, underemployed, and/or homeless families. Finally, due to limited funding and other factors, one setting was in a city,

located in the west United States, while the other setting was in a rural town, located in the mid-west United States. This constituted a difference in social contexts, influencing the sample populations and subsequent milieu effect measures.

Instrumentation

Given a climate of health care reform, the length of time approved by third party payers in both settings generally limited the duration of treatment to six sessions. Practitioners were therefore asked to follow sequences similar to those in the third treatment condition, adhering to the protocols set forth in each thoroughly discussed operational definition. Therapy integrity was measured by adherence to protocol, randomly and systematically observing practitioners to ensure uniformity. In determining the uniformity and internal consistency, the researcher was able to accurately discriminate between treatments on 100% of the sessions observed.

Considering limited treatment durations, the instrument chosen for this study was the Symptom Questionnaire (SQ), designed by Robert Kellner. This Questionnaire's known sensitivity to subtle changes in mood, when taken at intake and termination, quick and simple standardized administration and scoring, built in inconsistency scale, and high reliability and validity with sensitive measures, made it the ideal instrument for this study's comparative outcome measures.

In addition to its sensitivity and simplified procedures, the Symptom Questionnaire's general, yet sensitive measure of depressive moods constituted goals which prescriptive and exploratory therapy have in common, summarizing the generally accepted symptoms of depression. Measuring efficacy based upon the common goal of a mean change in depressive mood, the Symptom Questionnaire resolved the prior research issues of incongruence between treatment goals and measures

Practitioners

All six practitioners had a graduate level education and at least one year of supervised

professional experience. Differential practitioner effects were examined by comparing the mean change in depressive moods, during the design phase of the project. For all practitioners, this mean change was within one standard deviation of change for all participants in that particular treatment. This indicates that the impact of each therapist was fairly uniform within each modality.

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

Findings

One of the purposes of this study was to test the hypothesis that no significant differential outcome measures would result in the comparison of prescriptive and exploratory interventions, with increased efficacy in their integration. Another hypothesis was that the milieus in which various techniques were executed would increase the efficacy of those techniques with which they were congruent. The statistic used to test these hypotheses was a 2 X 3 ANOVA design, with two dichotomous, noncontinuous levels of milieu and three levels of the treatment variable.

Using Stataquest software, the 2 X 3 ANOVA revealed a significant effect for each Treatment ($F 95.24, p < .01$), no effect for Milieu ($F .09, p > .05$), and a significant effect for Treatment X Milieu ($F 13.97, p < .01$). Data for the ANOVA were entered into a Stataquest spreadsheet, arranged in case number, treatment category, milieu, and mood elevation columns (difference in SQ scores) columns.

While the resulting ANOVA table (Table 1) of inferential statistics revealed differential outcomes between treatments, it failed to adequately depict the specific nature of those differences. Table 2, a table of means, standard deviations, and frequencies, better depicted the nature of differences between Prescriptive (1), Exploratory (2), and Integrated (3) treatments, while also depicting the absence of milieu effects within column totals. To further clarify this data, from inferential and descriptive statistics, a box plot graphical exploration (table 3), graphical histogram presentation (table 4), and interaction plot were created, using Stataquest software.

Upon testing the reasonability of distributions, the results of the box plot graphical

exploration (table 3) revealed outliers in exploratory treatment measures, suggesting occasional skewness in the data. The graphical histogram presentation (table 4) by Prescriptive (1), Exploratory (2), and Integrated (3) treatments helped to clarify outlier frequencies, demonstrating reasonably well behaved distributions, with low frequency outliers. Finally, the interaction plot in table 5 depicted the significance and direction of the interaction between the various levels of treatment and milieu variables. Looking at these depictions of the data, it appeared that combined interventions were more effective than single theory interventions, and that milieus had the effect of balancing single theory interventions, unexpectedly increasing the efficacy of those interventions with which they were incongruent.

Summary

The review of research literature for the treatment of depression revealed a controversy in the proper implementation of brief interventions. The primary focus of such controversy concerned the efficacy of Prescriptive (directive, strategic, cognitive-behavioral) Brief Therapy versus Exploratory (non-directive, insight focused, psycho dynamic) Brief Therapy models. Related to this controversy were the philosophical differences built into the therapeutic milieus (designed therapeutic environments), which appeared to influence the efficacy of either set of interventions. Observing differences in mood, following Prescriptive, Exploratory, and combined techniques, within various settings, a sensitive instrument was selected to measure the comparative efficacy of matched techniques and environments. The purpose of the study was to test the hypothesis that no significant differential outcomes would result in the comparison of the two models, with increased efficacy in their integration. Milieus which were congruent with each model were further expected to yield increased efficacy.

In agreement with expectations, outcome measures revealed significantly higher elevations in mood following combined interventions or techniques, with unexpected significant interactions

between equally effective models and their unmatched environments. The implications of the data contrast with historical assumptions that prescriptive and exploratory models are incompatible, also contrasting with prior studies and theories advocating for treatment-environment congruency.

CHAPTER 5

SUMMARY; CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The results of the present study are consistent with the hypothesis that the efficacy of prescriptive and exploratory brief therapies would increase with their standardized integration. As in prior studies (Blatt and Maroudas, 1992, p.158), prescriptive and exploratory therapies demonstrated relatively equal effectiveness in the treatment of depression, elevating moods, based upon normal depressed patient baseline scores (10), by over forty percent. While prior studies may have indicated that prescriptive and exploratory therapy were incompatible, based upon their opposing theories, the present study conversely affirmed the increased efficacy (over 30%) yielded by integration.

Another purpose of the present study was to determine the impact of milieu upon treatment conditions, somewhat controlling or measuring the effects of the experimental environment. The direction of the resulting significant interaction between treatment and milieu contrasted with the hypothesis that treatment efficacy would be enhanced by a congruent milieu. Instead, the inferred effect of milieu was that it balanced single theory interventions, constituting another form of eclecticism. While prior studies with matched treatment and milieu variables showed that treatments were more effective when supported within a congruent milieu, the present study demonstrated the opposite. This effect may have been due to uncontrolled settings, nevertheless raising questions regarding prior research. Implications of these results point to further research on and control of the treatment environment.

Whether considering the effects of integration or treatment-environment incongruence, the

results of the present study support the contention that eclecticism increases efficacy, and is indeed possible by discarding erroneous notions of polarity between various schools of thought. Through technical eclecticism, the study demonstrated that the focus of treatment need not be action or insight, symptoms or causes, emotions or behavior. All of these elements are important to widespread applicability, and can be simultaneously considered. With novice practitioners looking for more uniform eclectic models, and consumers demanding their choice of modality and treatments, the present study promises more marketable and effective approaches for the years to come.

Although the present study was designed to provide more specific operational definitions, more treatment goal congruent outcome measures, and more defined milieus, it should be considered with caution. First, the study did not measure variances in treatment execution, which may explain the outliers in exploratory effects, also making it difficult to determine whether the limited theoretical basis of the third treatment condition had any confounding effects. Second, the study took place in two different regions of the country, in settings which primarily served women, and in settings which primarily attract homeless populations. These factors may have had an impact upon the results that was not measured and can therefore not be discerned.

Recommendations

The results of this research and study implicate the need for practitioners to be cognizant of the political climate in which they practice. Political and economic forces are always present in fields which operate on health care and government funding. Another factor which influences the practice of psychotherapy is the academic arena. Competition for grants and scholarships, status, and tenure may all influence the scope and direction of current research and practice.

With the influence of political, economic, and academic forces in mind, technical eclecticism may be seen in a new light. With technical eclecticism, only those techniques which have been proven

effective in repeated trials are utilized. There is more of a possibility therefore, that the practitioner will objectively select techniques based upon their merit.

While eclecticism may seem the answer to polarity and dogma, it too has its limitations. With focus upon technique, original theories and therapeutic goals may become clouded or lost. Without a theory and goals in place, therapy could become too ambiguous, without direction. It would be advisable to therefore create one's own theories, based upon those techniques which have stood the test of time and repeated trials.

In terms of research, the challenge is to isolate variables of interest, without creating an unrealistic scenario for study. While natural environments will always prevent assurances of uniformity, an experimental laboratory would not necessarily reflect that which might occur in a natural clinical setting. Still, it may be useful to test the methodology of this study in more controlled environments.

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APPENDIX

TABLE 1

Inferential Statistics: 2X3 ANOVA,
Calculated by Stataquest Software.

Variable 1: Treatment Conditions

Variable 2: Milieu

Number of obs = 210 R-squared = 0.5158
Root MSE = 1.11397 Adj R-squared = 0.5039

Source	Partial SS	df	MS	F	Prob > F
Model	269.631648	5	53.9263296	43.46	0.0000
var1	236.377093	2	118.188546	95.24	0.0000
var2	.113185186	1	.113185186	0.09	0.7630
var1*var2	34.6785582	2	17.3392791	13.97	0.0000
Residual	253.149304	204	1.24092796		
Total	522.780952	209	2.50134427		

TABLE 2

Descriptive Statistics: Table of Means, Standard Deviations, and Frequencies,
 Calculated by Stataquest Software.

Treatment 1: Prescriptive Brief Therapy

Milieu 1: Prescriptive Milieu

Treatment 2: Exploratory Brief Therapy

Milieu 2: Exploratory Milieu

Treatment 3: Brief (Eclectic) Empowerment Therapy

Treatment	Milieu		
	1	2	Total
1	4.3030303	5.4411765	4.880597
	.91804304	1.0499979	1.1351463
	33	34	67
2	5.2162162	4.3888889	4.8082192
	1.227806	1.1533251	1.25452
	37	36	73
3	7.1714286	7	7.0857143
	.89066117	1.3503812	1.1388127
	35	35	70
Total	5.5809524	5.6	5.5904762
	1.567586	1.602882	1.5815639

TABLE 3

*Graphical Exploration: Box Plot by Treatments,
Calculated by Stataquest Software.*

Treatment 1: Prescriptive Brief Therapy

Treatment 2: Exploratory Brief Therapy

Treatment 3: Brief (Eclectic)Empowerment Therapy

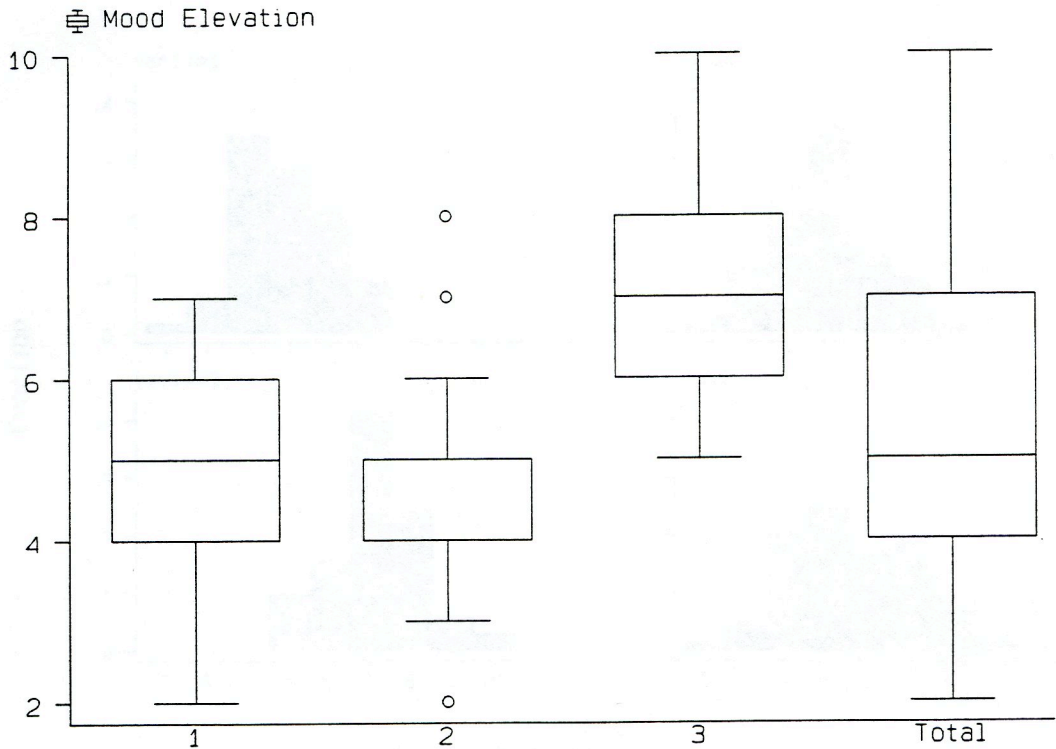


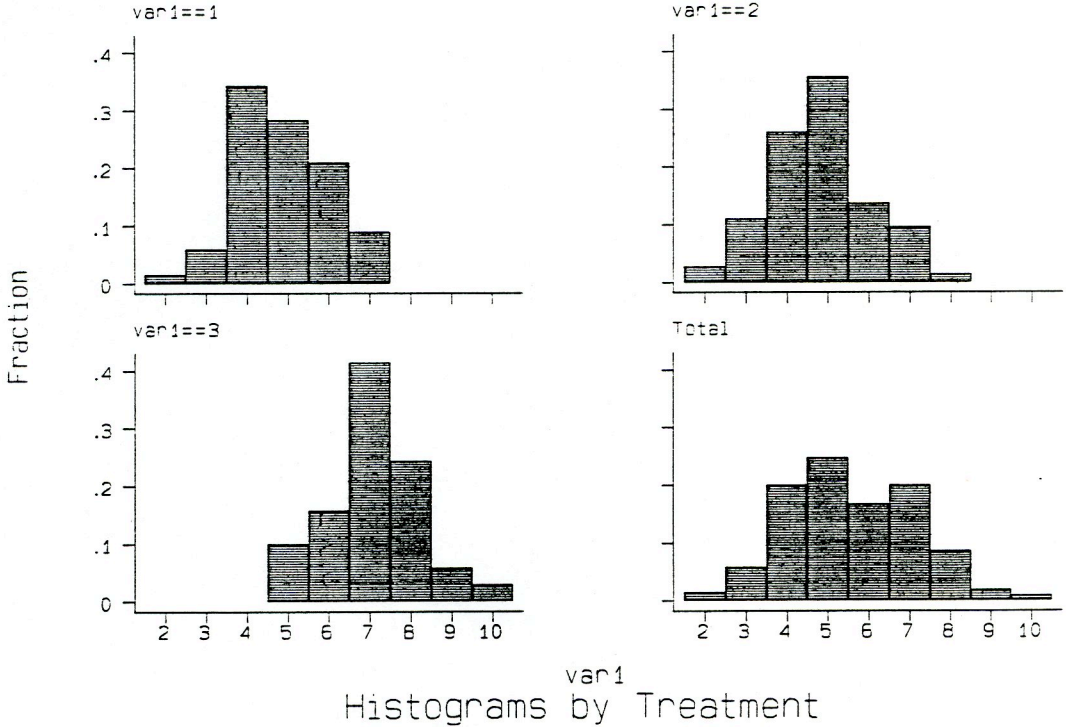
TABLE 4

*Graphical Histogram: A Depiction of Score Frequencies,
Created by Stataquest.*

Treatment 1: Prescriptive Brief Therapy

Treatment 2: Exploratory Brief Therapy

Treatment 3: Brief (Eclectic) Empowerment Therapy



12	43378	OTTAWA:THS	
161	MIS	10/06/99	5090